FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045753

Facility Name: Litchfield HealthCare Center

Address: 1285 East Union Avenue (Number) Litchfield (City) 62056 (Zip Code)

County: Montgomery

Telephone Number: (217) 324-3996 **Fax #** (217) 324-6032

IDPA ID Number: 38-2795206

Date of Initial License for Current Owners: 02/19/1992

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sherry L DeBons **Telephone Number:** (832) 467-6323

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Linda Holtzscheiter
(Title) Reimbursement Manager

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 1/1/2003 Ending: ########

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	26	9,516	1
2		Skilled Pediatric (SNF/PED)			2
3	97	Intermediate (ICF)	97	35,502	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	45,018	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,731	947	4,308	6,986	8
9	SNF/PED					9
10	ICF	18,643	4,947	167	23,757	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,374	5,894	4,475	30,743	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.29%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 01/01/1992

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 01/01/1992 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 26 and days of care provided 4,308

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	150,486	11,742	7,047	169,275		169,275		169,275			1
2	Food Purchase		135,039		135,039	(3,720)	131,319		131,319			2
3	Housekeeping	74,304	8,934		83,238		83,238		83,238			3
4	Laundry	68,557	13,809		82,366		82,366		82,366			4
5	Heat and Other Utilities			117,353	117,353		117,353	30	117,383			5
6	Maintenance	32,862	32,248	9,501	74,611		74,611	190	74,801			6
7	Other (specify):* Waste/Garbage -See pg 3.1			18,358	18,358		18,358		18,358			7
8	TOTAL General Services	326,209	201,772	152,259	680,240	(3,720)	676,520	220	676,740			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,217,081	59,839	13,115	1,290,035		1,290,035	15,847	1,305,882			10
10a	Therapy	164,893	14,559	982	180,434		180,434		180,434			10a
11	Activities	34,544	1,308	2,261	38,113		38,113	2,096	40,209			11
12	Social Services	10,400		2,559	12,959		12,959		12,959			12
13	Nurse Aide Training			315	315		315		315			13
14	Program Transportation			2,848	2,848	(2,848)						14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,426,918	75,706	31,080	1,533,704	(2,848)	1,530,856	17,943	1,548,799			16
	C. General Administration											
17	Administrative	55,119			55,119		55,119		55,119			17
18	Directors Fees											18
19	Professional Services			338	338		338		338			19
20	Dues, Fees, Subscriptions & Promotions			15,739	15,739		15,739	(2,033)	13,706			20
21	Clerical & General Office Expenses	155,333	6,873	350,645	512,851		512,851	(163,546)	349,305			21
22	Employee Benefits & Payroll Taxes			402,836	402,836	3,720	406,556	(3,720)	402,836			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,193	11,193		11,193	9,356	20,549			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			78,514	78,514		78,514	(113)	78,401			26
27	Other (specify):*											27
28	TOTAL General Administration	210,452	6,873	859,265	1,076,590	3,720	1,080,310	(160,055)	920,255			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,963,579	284,351	1,042,604	3,290,534	(2,848)	3,287,686	(141,893)	3,145,793			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Litchfield HealthCare Center #0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			18,321	18,321		18,321	51,097	69,418			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(1,257)	(1,257)		(1,257)	1,257				32
33	Real Estate Taxes			67,943	67,943		67,943	(5,151)	62,792			33
34	Rent-Facility & Grounds			150,000	150,000		150,000	1,693	151,693			34
35	Rent-Equipment & Vehicles			9,590	9,590		9,590	1,170	10,760			35
36	Other (specify):* Home Office							10,263	10,263			36
37	TOTAL Ownership			244,597	244,597		244,597	60,329	304,926			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					2,848	2,848	(2,848)				38
39	Ancillary Service Centers		81,355		81,355		81,355	13,173	94,528			39
40	Barber and Beauty Shops		1,387	9,057	10,444		10,444	(1,387)	9,057			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,343	67,343		67,343		67,343			42
43	Other (specify):*			21,235	21,235		21,235		21,235			43
44	TOTAL Special Cost Centers		82,742	97,635	180,377	2,848	183,225	8,938	192,163			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,963,579	367,093	1,384,836	3,715,508		3,715,508	(72,626)	3,642,882			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,720)	22		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	1,257	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(130,865)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(140,060)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (273,388)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	200,762		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 200,762		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (72,626)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	x		$ 2,848	14	38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 2,848		47

STATE OF ILLINOIS

Litchfield HealthCare Center

ID# 0045753

Report Period Beginning: 01/01/2003

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Sales Taxes	$ (259)	21	1
2	Small Balance Adjustment	0	21	2
3	Memorium/ Benevolance	0	21	3
4	Depreciation Reconciliation	51,097	30	4
5	Activities Program Receipts	0	11	5
6	Property Tax adjust to Actual	(5,369)	33	6
7	Professional liability Insurance	(546)	26	7
8	Barber & beauty	(1,387)	40	8
9	Public Relations Expenses	0	20	9
10	Non Allowable Advertising	(2,701)	20	10
11	Entertaiment	(960)	24	11
12	Rental Receipts	(50)	21	12
13	Civic Dues	(350)	20	13
14	Penalities	6,873	21	14
15	Vending reciepts	(1,386)	21	15
16	Misc Reciepts	(22)	21	16
17	Marketing Wages	(7,083)	21	17
18	Marketing Bonus	(11,533)	21	18
19	Marketing Holiday	(288)	21	19
20	Maketing Sick	0	21	20
21	Marketing Vacation	1,074	21	21
22	Marketing Overtime	0	21	22
23	Marketing Non Worked Wages	0	21	23
24	Donations/ Contributions	0	21	24
25	Legal Fees - Bankrupcty	0	21	25
26	Legal Structure Management Fees	(172,484)	21	26
27	Disallow Travel undocumentated	(1,940)	24	27
28	Transportation	(2,848)	38	28
29				29
30	**Asset <500 Asset #5025**	861	10	30
31	**Asset <500 Asset #5026**	57.63	10	31
32	**Asset <500 Asset #5027**	2212.5	10	32
33	**Asset <500 Asset #5028**	149.34	10	33
34	**Asset <500 Asset #5029**	467.28	11	34
35	**Asset <500 Asset #5030**	31.54	11	35
36	**Asset <500 Asset #5031**	636.9	11	36
37	**Asset <500 Asset #5032**	47.04	11	37
38	**Asset <500 Asset #5050**	897.76	21	38
39	**Asset <500 Asset #5051**	756.09	21	39
40	**Asset <500 Asset #5057**	3071.58	21	40
41	Asset <1500 Asset # 5055	790.58	11	41
42	Asset <1500 Asset # 5056	123.05	11	42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(140,060)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Litchfield HealthCare Center # 0045753 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	30	0	0	0	0	0	0	0	0	0	30	5
6	Maintenance	0	190	0	0	0	0	0	0	0	0	0	190	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	220	0	0	0	0	0	0	0	0	0	220	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	3,281	12,566	0	0	0	0	0	0	0	0	0	15,847	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	2,096	0	0	0	0	0	0	0	0	0	0	2,096	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	5,377	12,566	0	0	0	0	0	0	0	0	0	17,943	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,051)	1,018	0	0	0	0	0	0	0	0	0	(2,033)	20
21	Clerical & General Office Expenses	(311,298)	147,752	0	0	0	0	0	0	0	0	0	(163,546)	21
22	Employee Benefits & Payroll Taxes	(3,720)	0	0	0	0	0	0	0	0	0	0	(3,720)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,900)	12,256	0	0	0	0	0	0	0	0	0	9,356	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(546)	433	0	0	0	0	0	0	0	0	0	(113)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(321,514)	161,459	0	0	0	0	0	0	0	0	0	(160,055)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(316,138)	174,245	0	0	0	0	0	0	0	0	0	(141,893)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Litchfield HealthCare Center # 0045753 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	51,097	0	0	0	0	0	0	0	0	0	0	51,097	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	1,257	0	0	0	0	0	0	0	0	0	0	1,257	32
33	Real Estate Taxes	(5,369)	218	0	0	0	0	0	0	0	0	0	(5,151)	33
34	Rent-Facility & Grounds	0	1,693	0	0	0	0	0	0	0	0	0	1,693	34
35	Rent-Equipment & Vehicles	0	1,170	0	0	0	0	0	0	0	0	0	1,170	35
36	Other (specify):*	0	10,263	0	0	0	0	0	0	0	0	0	10,263	36
37	**TOTAL Ownership**	46,985	13,344	0	0	0	0	0	0	0	0	0	60,329	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(2,848)	0	0	0	0	0	0	0	0	0	0	(2,848)	38
39	Ancillary Service Centers	0	13,173	0	0	0	0	0	0	0	0	0	13,173	39
40	Barber and Beauty Shops	(1,387)	0	0	0	0	0	0	0	0	0	0	(1,387)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(4,235)	13,173	0	0	0	0	0	0	0	0	0	8,938	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(273,388)	200,762	0	0	0	0	0	0	0	0	0	(72,626)	45

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Health Care	100	See Attachment page 6.1		Mariner Health Care	Atlanta, GA	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Health Care	100.00%	$ 30	$ 30	1
2	V	6	Repair & Maintenance		Mariner Health Care	100.00%	190	190	2
3	V	39	Professional Services		Mariner Health Care	100.00%	13,173	13,173	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Health Care	100.00%	1,018	1,018	4
5	V	10	Nursing & Medical Records		Mariner Health Care	100.00%	12,566	12,566	5
6	V	21	Clerical & General Office Exp		Mariner Health Care	100.00%	147,752	147,752	6
7	V	24	Travel & Seminar		Mariner Health Care	100.00%	12,256	12,256	7
8	V	26	Insurance Premium		Mariner Health Care	100.00%	317	317	8
9	V	36	Depreciation		Mariner Health Care	100.00%	10,263	10,263	9
10	V	33	Taxes - Property		Mariner Health Care	100.00%	218	218	10
11	V	35	Rental & Leasing		Mariner Health Care	100.00%	1,170	1,170	11
12	V	34	Leasse Expense		Mariner Health Care	100.00%	1,693	1,693	12
13	V	26	Property Insurance		Mariner Health Care	100.00%		116	13
14	Total			$			$ 200,646	$ * 200,762	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Health Care
Street Address: One Ravine Dr. Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: ((770) 379-8203
Fax Number: ((770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities				$ 30	$		$ 30	1
2	6	Repair & Maintenance				190			190	2
3	39	Professional Services				13,173			13,173	3
4	20	Fees, Subscriptions, Promotions				1,018			1,018	4
5	10	Nursing & Medical Records				12,566			12,566	5
6	21	Clerical & General Office Exp				147,752			147,752	6
7	24	Travel & Seminar				12,256			12,256	7
8	26	Insurance Premium				317			317	8
9	36	Depreciation				10,263			10,263	9
10	33	Taxes - Property				218			218	10
11	35	Rental & Leasing				1,170			1,170	11
12	34	Leasse Expense				1,693			1,693	12
13	26	Property Insurance				116			116	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 200,762	$		$ 200,762	25

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 62,053	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 62,573	2
3. Under or (over) accrual (line 2 minus line 1).		$ 520	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 67,423	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 67,943	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	55,504	8
	1999	48,854	9
	2000	59,331	10
	2001	58,945	11
	2002	62,573	12

Line 4...Accrual is the balance in G/L 220100 22010 0000 plus 1 due to rounding

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Litchfield HealthCare Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0045753

CONTACT PERSON REGARDING THIS REPORT Sherry DeBons

TELEPHONE (832) 467-6323 FAX #: (832) 467-6336

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200.

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-100-598-05	PT W 1/2 SW Lands Corp Limits	$ 59,586.06	$ 59,586.06
2.	11-100-598-00	PT W 1/2 SW Lands Corp Limits	$ 2,987.26	$ 2,987.26
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 62,573.32	$ 62,573.32

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,189 B. General Construction Type: Exterior Masonary Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [x] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Building Inprovement			1982	2,131		20			2,131	10
11	Building Inprovement			1983	2,986		20			2,986	11
12	Building Inprovement			1984	53,393	2,670	20	2,670		52,198	12
13	Building Inprovement			1985	55,378	2,771	20	2,771		52,068	13
14	Building Inprovement			1986	2,920	146	20	146		2,548	14
15	Building Inprovement			1989	5,059	253	20	253		3,498	15
16	Building Inprovement			1990	3,677	184	20	184		2,402	16
17	Building Inprovement			1991	3,100	155	20	155		2,004	17
18	Building Inprovement			1992	10,816	541	20	541		6,277	18
19	See Attached Schedule - Page 12.1			1993	14,559	728	20	728		18,311	19
20	See Attached Schedule - Page 12.2			1994	94,548	2,429	20	2,429		23,392	20
21	Windows			1996	599	30	20	30		211	21
22	Rooftop A/C Unit			1996	8,850	443	20	443		3,156	22
23	Painting			1996	5,000	250	20	250		1,892	23
24	Air Conditioner			1997	3,416	171	20	171		1,107	24
25	Fire Alarm System			1997	732	37	20	37		230	25
26	Ground Sign			1997	2,900	145	20	145		975	26
27	Paving /Sidewalks Repair			1998	950	63	15	63		374	27
28	HVAC			1998	10,764	538	20	538		3,183	28
29	HVAC - Condensor Replacement Unit			1998	4,275	285	15	285		1,496	29
30	Capet			1998	6,276	1,255	5	1,255		5,666	30
31	Landscaping			1998	6,222	622	20	622		3,387	31
32	Handicap Ramp			1998	950	48	20	48		274	32
33	Fire Alarm System			1999	6,809	681	10	681		3,405	33
34	Replc. 2 AO Smith Water			1999	12,500	1,250	10	1,250		6,042	34
35	6: Isandaire A/C Heaters			1999	6,267	1,253	5	1,253		4,424	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Condensor & Coil Rpr W/N Freezer	2000	$ 3,800	$ 253	15	$ 253	$	$ 1,076	37
38	Elec Transfer Switch Instld	2000	2,675	268	10	268		1,161	38
39	F/A Smoke Detection Inspect	2000	782	78	10	78		286	39
40	2: Islandaire Heat/Cool Units	2000	2,168	217	10	217		832	40
41	Architect Serv. F/A Systems	2000	16,988	1,699	10	1,699		5,946	41
42	10: 12 BTU HVAC Units	2000	11,038	736	15	736		2,514	42
43	Architect Fees, FA System	2000	8,612	861	10	861		2,870	43
44	Wter Heater - Laundry	2000	5,400	540	10	540		1,710	44
45	Arch Retainage & Reimbursement	2000	5,238	524	10	524		1,659	45
46	Rplc Fire Alarm System App No.1	2000	85,313	8,531	10	8,531		27,015	46
47	Rplc Fire Alarm System App No. 2	2000	45,074	4,507	10	4,507		14,272	47
48	Arch Fee, Reimburse, 11%	2001	3,379	338	10	338		1,042	48
49	Constr fee, Fire alarm, App #3 (2.5%)	2001	3,343	334	10	334		1,031	49
50	7: Islandaire HVAC Units	2001	7,140	476	15	476		1,246	50
51	Use Tax -7 : Islandiare HVAC Units	2001	446	30	15	30		87	51
52	R Concrete, Employee Entrance	2001	1,520	101	15	101		261	52
53	R Concrete, N. Emergency Entrance	2001	1,635	109	15	109		282	53
54	Rprs Roof & Gutters, Pat Rm	2001	3,649	365	10	365		852	54
55	Nurse Call System Ungrade	2001	4,350	435	10	435		943	55
56									56
57	Service, Nurse Call system	2002	830	83	10	83		180	57
58	Domestic W/H Investigation	2002	2,100	210	10	210		490	58
59	Architect fees - Blue Prints	2002	900	60	15	60		115	59
60	2: Fire Rated Exit Device	2002	6,753	675	10	675		1,069	60
61	Rplc Doors & frames	2002	16,358	1,091	15	1,091		1,727	61
62	Floor Prep Base Tile work	2002	15,246	1,016	15	1,016		1,694	62
63	Plumbing / Kitchen	2002	5,627	281	20	281		469	63
64	Rprs Wall & Door - Kitchen	2002	9,664	644	15	644		1,074	64
65	Electrical Work -Kitchen	2002	1,063	53	20	53		89	65
66	Ext Reclamation / Concrete Patch	2002	2,194	146	15	146		244	66
67	Horns & Strobes Instl - F/A System	2002	2,850	285	10	285		451	67
68	HVAC RTU - 2nd floor Hall N Station	2002	6,695	446	15	446		632	68
69									69
70	TOTAL (lines 4 thru 69)		$ 607,906	$ 42,342		$ 42,342	$	$ 276,955	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 607,906	$ 42,342		$ 42,342	$	$ 276,955	1
2	HVAC RTU 1st Floor TV Roon	2002	7,102	473	15	473		671	2
3	Architect Fees / Convent Beds	2002	6,230	415	15	415		588	3
4	Arch Fee Pat Rm Wardrobes	2002	387	26	15	26		30	4
5									5
6	WanderGuard Syst-Intl	2003	688	57	10	57		57	6
7	Rprs WanderGuard Sys	2003	934	86	10	86		86	7
8	2: Door Closer -WanderGuard	2003	1,067	80	10	80		80	8
9	Auto Fire Propection	2003	2,600	173	10	173		173	9
10	WanderGuard Sys Instl	2003	6,651	499	10	499		499	10
11	WanderGuard Sys Instl	2003	30,049	2,504	10	2,504		2,504	11
12	Rplc 848: ceiling Tiles	2003	5,168	201	15	201		201	12
13	Arch & Eng Fee Wardr	2003	444	20	15	20		20	13
14	Use Tax Arch & Eng Fee Wardr	2003	30	1	15	1		1	14
15	Replc HVSRTU #4	2003	7,528	251	15	251		251	15
16	Ceiling Mounted Exhaust Fan	2003	5,817	291	10	291		291	16
17	2 Ton Condensing Unit Air Hand	2003	8,047	268	15	268		268	17
18	2: 5Ton A/R Unit Kitchen	2003	16,728	836	10	836		836	18
19	Lumber -Gazebo	2003	791	20	10	20		20	19
20	Rocks, 8Ton Dirt - Gazebo	2003	123	3	10	3		3	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 708,288	$ 48,547		$ 48,547	$	$ 283,534	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 166,873	$ 18,722	$ 18,722	$	var	$ 105,500	71
72	Current Year Purchases	20,740	2,150	2,150		var	2,150	72
73	Fully Depreciated Assets	332,763					332,763	73
74								74
75	TOTALS	$ 520,376	$ 20,872	$ 20,872	$		$ 440,413	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,228,664	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 69,418	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 69,418	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 723,947	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	O/H Allocation 1996	$ 1,166	$ 59	$ 421	86
87	O/H Allocation 1997	2,262	113	720	87
88					88
89					89
90					90
91	TOTALS	$ 3,428	$ 172	$ 1,141	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Nationwide Health Properties -(Merger to) Omega Healthcare Partners, L.P. as of Sept 27,1991

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	123	07/01/89	$ 150,000	10	40	3
4	Additions							4
5								5
6								6
7	TOTAL		123		$ 150,000 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [x] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 07/01/89
Ending 06/01/06

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 6,002 Description: Dishwasher, copier & postage machine
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Activities & Errands	2001 Ford XE-350 Super	$ var	$ 9,590	17
18		Van			18
19					19
20					20
21	TOTAL		$	$ 9,590	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a -03	2011	hrs	$ 57,125		$	$	2,011	$ 57,125	1
2	Licensed Speech and Language Development Therapist	10a -03	256	hrs	8,476				256	8,476	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a -03	3716	hrs	100,850			148	3,716	100,998	4
5	Physician Care	39 - 03		visits							5
6	Dental Care	39 - 03		visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39 - 03		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)	39 - 03		hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 166,451		$	$ 148	5,983	$ 166,599	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Litchfield HealthCare Center # 0045753 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,500	$	1
2	Cash-Patient Deposits	43,807		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	11,827		3
4	Supply Inventory (priced at)	12,128		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See attachment Schd 17.1			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 69,262	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	166,832		15
16	Equipment, at Historical Cost	54,559		16
17	Accumulated Depreciation (book methods)	(24,910)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See attachment Schd 17.1	(3)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 196,478	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 265,740	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 47,646	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(12,736)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	150,102		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,276		31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,422		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attachment Schd 17.1	54,439		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 311,149	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See attachment Schd 17.1	(385,584)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (385,584)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (74,435)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 340,175	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 265,740	$	48

***(See instructions.)**

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 308,779	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 308,779	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(209,695)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (209,695)	17
	B. Transfers (Itemize):		
18	**Fresh Start Acctg Due to Bankrupty**		18
19	**Move CYRE to Retained Earning**	255,644	19
20	**Close net effect to RE**	(14,552)	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 241,092	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 340,176	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,309,401	1
2	Discounts and Allowances for all Levels	(1,665,472)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,643,929	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	485,027	6
7	Oxygen	8,134	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 493,161	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	13,723	13
14	Non-Patient Meals	5,230	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	142,100	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	150,518	19
20	Radiology and X-Ray	1,162	20
21	Other Medical Services	54,532	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 367,265	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Receipts & Rental Receipts	72	28
28a	Misc receipts	1,386	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,458	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,505,813	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	680,239	31
32	Health Care	1,533,704	32
33	General Administration	1,076,591	33
	B. Capital Expense		
34	Ownership	244,597	34
	C. Ancillary Expense		
35	Special Cost Centers	113,034	35
36	Provider Participation Fee	67,343	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,715,508	40
41	**Income before Income Taxes (line 30 minus line 40)****	(209,695)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (209,695)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,033	2,198	$ 62,921	$ 28.63	1
2	Assistant Director of Nursing	1,937	2,094	39,879	19.04	2
3	Registered Nurses	4,930	5,330	98,675	18.51	3
4	Licensed Practical Nurses	18,582	20,088	338,554	16.85	4
5	Nurse Aides & Orderlies	56,538	61,121	629,741	10.30	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,257	4,649	128,446	27.63	7
8	Rehab/Therapy Aides	1,681	1,836	36,447	19.85	8
9	Activity Director	1,825	1,967	18,266	9.29	9
10	Activity Assistants	2,204	2,377	16,278	6.85	10
11	Social Service Workers	992	1,118	10,400	9.30	11
12	Dietician					12
13	Food Service Supervisor	2,022	2,171	29,523	13.60	13
14	Head Cook	6,571	7,052	61,809	8.76	14
15	Cook Helpers/Assistants	7,884	8,461	59,155	6.99	15
16	Dishwashers					16
17	Maintenance Workers	2,528	2,806	32,862	11.71	17
18	Housekeepers	8,996	9,599	74,304	7.74	18
19	Laundry	7,595	8,172	68,557	8.39	19
20	Administrator	1,905	2,086	71,786	34.41	20
21	Assistant Administrator					21
22	Other Administrative	1,918	2,101	40,605	19.33	22
23	Office Manager					23
24	Clerical	4,316	4,726	80,231	16.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	869	1,047	11,254	10.75	31
32	Other Health Ca Care Coor Case M	2,016	2,016	36,056	17.88	32
33	Other(specify) Mkting & Transpo	393	414	17,829	43.07	33
34	TOTAL (lines 1 - 33)	141,992	153,429	$ 1,963,578 *	$ 12.80	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	152	$ 6,137	1 - 3	35
36	Medical Director	35	9,000	9 - 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	276	11,114	10 - 7	38
39	Pharmacist Consultant	43	4,631	10 -3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	43	2,359	11 - 3	44
45	Social Service Consultant	43	2,377	12 - 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	592	$ 35,618		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ none		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mary Buffington	Adminstrator	100%	$ 55,119
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 55,119

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Legal	Legal fees	$ 338
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 338

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,785
Unemployment Compensation Insurance	46,738
FICA Taxes	139,415
Employee Health Insurance	133,897
Employee Meals	3,720
Illinois Municipal Retirement Fund (IMRF)*	
Pension / retirment	1,413
insurance Life	3,120
Other Benefits	2,468
Home Office Allocation	0
Less Meals not allowable	(3,720)
TOTAL (agree to Schedule V, line 22, col.8)	$ 402,836

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,061
Health Care Worker Background Check (Indicate # of checks performed)	1,648
Other Licenses Fees	1,280
Dues	6,301
Home Office Allocation	1,018
Total Advertising	4,450
Less: Public Relations Expense	(350)
Non-allowable advertising	(1)
Yellow page advertising	(2,701)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,706

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 53
In-State Travel	7,572
Home Office allocation	12,256
Seminar Expense	1,628
Entertainment Expense	(960)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,549

**See instructions.

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Report Period Beginning: 01/01/2003 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Litchfield HealthCare Center # 0045753 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois HealthCare Association - $5800**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,711** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **67,343**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,720** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,720**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/a**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? ____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/a** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/a** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Operating Expense - Line 7	Amount
Infectious Waste Disposal <> Default <> Nursing Admin/Supv	14,478
Infectious Waste Disposal <> Default <> Physical Plant	0
Garbage Service<>Default<>Prod<>Physical Plant	0
Garbage Service <> Default <> Physical Plant	3,880
	18,358

Health Care Program - Line 15	Amount
N/A	
	0

General & Adminstrative - Line 27	Amount
N/A	
	0

Inservice Education - Line 23 Column 3 (over $2,000)	Amount
N/A	
	0

STATE OF ILLINOIS

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Ending: 12/31/03

Meals - adjustment

30,743	Days (Total Patient days)
3	Mult (3 meals a day)
92229	Sub total
2613	meals to employess (reported by facility)
94842	Add Sub
135039	Divide -Pg 3, line 2, column 2
1.42	Cost per day

1.42	Cost per day
2613	mult - meal to employees
3,720	= adjust for pg 2, line 2, column2

Sales Tax - adjustment

135,039	Total Food Cost (page 3,Line 2, col 3)
0.01	Mult
1350.39	Sub total
19.17%	Mult (Pvt pay div by total census)
259	= adjust for nonallowable sale tax

for page 5A,

Reclassifiaction V

Page 3 Line 14

Res/Client Transportation<>Default<>Prod<>Tran 810004000003850	(2,848)	Reclass From
Page 4 line 38	2,848	Reclass to

STATE OF ILLINOIS

Facility Name & ID Number Litchfield HealthCare Center # 0045753 Ending: 12/31/03

SUPPLEMENTAL SCHEDULE OF OTHER EXPENSES

Ownership - Line 36	Amount
Fresh Start Acctg Adj <> Bankrupty Exp Acq <> Cost Non Overhead	0
	-

Ancillary Expenses - Line 43 -Column 2	Amount
Ancillary Cost of Goods Sold<>Default<>Prod<>Laboratory	0
	0

Ancillary Expenses - Line 43 -Column 3	Amount
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	0
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	0
Professional Services <> Nonchg<>Medical Director<>Laboratory	0
Professional Services <> Nonchg<>Medical Director<>X/Ray	0
Professional Services <> Nonchg<>Other Medical Professionals<>Labora	17,529
Professional Services <> Nonchg<>Other Medical Professionals<>X/Ray	3,706
	21,235

Related Illinois Nursing Homes as of 12/31/2003

Group Name	Related Illinois Nursing Homes	Illinois Facility Number
Mariner Health Care	LaSalle Health & Rehabilitation Center	0037671
	Litchfield HealthCare Center	0037689
	Montebello Healthcare Center	0031468
	Nature Trail HealthCare Center	0039586
	Odin HealthCare Center	0039503
	Mariner Health of Westchester	0042374

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

OTHER CURRENT ASSETS:	AMOUNT
Total	0
Reconcile with schedule XV, line 9:	0
Difference	0

OTHER CURRENT LIABILITIES:	AMOUNT
Accruals - Insurance <> Self Funded Ins Accr <> Default	(43,878)
Accruals - Insurance <> Basic Life <> Default	(659)
Accruals - Insurance <> Lt Dsblty <> Default	(272)
Accruals - Insurance <> Dental Ins <> Default	0
Accruals - Insurance <> Executive Supp Life <> Default	(188)
Accruals - Insurance <> Short Term Disability <> Default	(922)
Accruals - Insurance <> Dependent Life <> Default-Dept	(96)
Accruals - Insurance <> Accidental Death Dismemberment <> Default-Dept	(29)
Accruals - Insurance <> NES Insurance <> Default-Dept	(1,188)
Misc Dedctns - Employee <> Other Decductions <> Default	(7,207)
Total	(54,439)
Reconcile with schedule XV, line 36:	(54,439)
Difference	-

OTHER NON-CURRENT ASSETS:	
Excess Reorganized Value <>Excess Reorg Value <> Default	
Other Assets <> Rfndable Deposits-Non Int Brg <> Default	
Rounding	-3
Total	(3)
Reconcile with schedule XV, line 23:	(3)
Difference	-

OTHER NON-CURRENT LIABILITIES::	
Intercompany - Revolver <> Default <> Default	385,584
N/P - Mortgage <> Mortgages <> Default	
Total	385,584
Reconcile with schedule XV, line 43:	385,584
Difference	0

SUPPLEMENATAL SCHEDULE OF ASSETS & LIABILITIES

DESCRIPTION	AMOUNT
Personal Purchase Receipts <> Default <> Vending	0
Miscellaneous Receipts<>Default<>Prod<>Vending	
Miscellaneous Receipts<>Default<>Prod<>Administrative	(21.93)
General Rental Receipts<>Default<>Prod<>Administrative	(50.00)
Total	(71.93)
Difference	
Reconcile with schedule XVII, line 28:	(72)
	0

DESCRIPTIONS	
Personal Purchase Receipts <> Default <> Patient Personal Purchase	-
Personal Purchase Receipts <> Default <> Miscellaneous Receipts	-
Personal Purchase Expense <> Default <> Patient Personal Purchase	-
Miscellaneous Receipts <> Default-Prod <> Other Misc Rev	-
Activity Programs Receipts <> Default <> Other Misc Rev	-
Miscellaneous Receipts<>Default<>Prod<>Activities	
Miscellaneous Receipts<>Default<>Prod<>Vending	(1,386)
Total	(1,386)
Difference	
Reconcile with schedule XVII, line 28a:	(1,386)
	-